DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

FILED FEB 14 1941

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. 2386

Registration District No. 2403 — Primary Registration District No. 5336 — Registrar's No.

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

1. PLACE OF DEATH:
(a) County Dallas
(b) City or town Eldridge Rural
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: Parkview Home
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution ____ (Specify whether
In this community 2 years
years, months or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Missouri (b) County Dallas
(c) City or town Eldridge (Rural)
(If outside city or town limits, write "RURAL")
(d) Street No. ____ (If rural, give location)
(e) If foreign born, how long in U. S. A.? ____ years.

3. (a) PRINT FULL NAME Eliza D. Campbell
3. (b) If veteran, name war ____
3. (c) Social Security No. ____

4. Sex Female
5. Color or race White
6. (a) Single, widowed, married, divorced Widowed
6. (b) Name of husband or wife Johnny Campbell
6. (c) Age of husband or wife if alive ____ years
7. Birth date of deceased Dec 12 1870 (Month) (Day) (Year)

8. AGE: Years 70 Months 3 Days 9 If less than one day ____ hr. ____ min.

9. Birthplace Wright Co (City, town, or county) Mo (State or foreign country)
10. Usual occupation Housekeeper
11. Industry or business ____
MOTHER / FATHER
12. Name James Nichols
13. Birthplace Wright Co (City, town, or county) Mo (State or foreign country)
14. Maiden name Mary Munn
15. Birthplace Wright Co (City, town, or county) Mo (State or foreign country)
16. (a) Informant Mattie Nichols
(b) Address Eldridge Mo
17. (a) Marshfield (Burial, cremation, or removal) (b) Date thereof 1-22-1941 (Month) (Day) (Year)
(c) Place: burial or cremation ____
18. (a) Signature of funeral director J B Jones
(b) Address Buffalo Mo
19. (a) 1-25-41 (Date received local registrar) (b) Mrs D N Shewmaker (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Jan day 21 year 1941 hour 7 minute 30 P.M.

21. I hereby certify that I attended the deceased from 1-9, 1941, to 1-21, 1941; that I last saw him alive on 1-21, 1941; and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death Pneumonia	
Due to Chronic T.B.	
Due to ____	
Other conditions (Include pregnancy within 3 months of death) ____	
Major findings: Of operations ____	
Of autopsy ____	

PHYSICIAN — Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide (specify) ____
(b) Date of occurrence ____
(c) Where did injury occur? ____ (City or town) (County) (State)
(d) Did injury occur in or about home, on farm, in industrial place, in public place? (Specify type of place)
While at work? ____ (e) Means of injury ____

23. Signature J W Lindsay (M. D. or other) M.D.
Address Conway Date signed ____

(Licensed Embalmer's Statement on Reverse Side)

RECEIVED
District Health Officer No. 7,
District File Number 2-41-179
Date Filed 2-4-41

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me, or by ....., Registered Apprentice No. .....
working under my personal supervision.

Signed L. B. [illegible]

Licensed Embalmer No. 2508

P. O. Address Bingham Me

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comp.. the above constitutes grounds for revocation of license.)

If this body is not embalmed, fact should be so stated above.

No. 2B
-2-21-40
I X22659

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No. 2386

Registration District No. 243 — Primary Registration District No. 5336 — Registrar's No.

1. PLACE OF DEATH:
(a) County Dallas
(b) City or town Jackson T. P.
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution (Specify whether years, months or days) In this community

2. USUAL RESIDENCE OF DECEASED:
(a) State (b) County
(c) City or town
(If outside city or town limits write "RURAL")
(d) Street No. (If rural, give location)
(e) If foreign born, how long in U. S. A.? years.

3. (a) PRINT FULL NAME Eliza D Campbell
3. (b) If veteran, name war
3. (c) Social Security No.

4. Sex F
5. Color or race W
6. (a) Single, widowed, married, divorced wid
6. (b) Name of husband or wife
6. (c) Age of husband, or wife, if alive years

7. Birth date of deceased (Month) (Day) (Year)

8. AGE: Years 70 | Months 3 | Days 9 | If less than one day hr. min.

9. Birthplace (City, town, or county) (State or foreign country)
10. Usual occupation
11. Industry or business
MOTHER / FATHER
12. Name
13. Birthplace (City, town, or county) (State or foreign country)
MOTHER
14. Maiden name
15. Birthplace (City, town, or county) (State or foreign country)
16. (a) Informant
(b) Address
17. (a) (Burial, cremation, or removal) (b) Date thereof (Month) (Day) (Year)
(c) Place: burial or cremation
18. (a) Signature of funeral director
(b) Address
19. (a) (Date received by local registrar) (b) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Jan day 21
year 1941 hour minute M.
21. I hereby certify that I attended the deceased from , 19 , to , 19 ; that I last saw h alive on , 19 ; and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death Flue	
Due to Chronic T. B. of Lungs	
Due to	
Other conditions (Include pregnancy within 3 months of death)	
Major findings: Of operations	
Of autopsy	

PHYSICIAN — Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide (specify)
(b) Date of occurrence
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur in or about home, on farm, in industrial place, in public place? (Specify type of place)
While at work? (e) Means of injury

23. Signature J. W. Simmons (M. D. or other) M.D.
Address Conway Date signed

SUPPLEMENTARY